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Psychological Profile and Consumption of Healthcare Resources in Actively Employed People, Pre-Retirees, and Retirees

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Abstract: Research on personality variables and consumption of health services in actively employed people or retirees has been extensive, but the group of pre-retirees has hardly been studied. This work attempts to determine the mental health and use of health resources of the three groups, hypothesizing that, as the group of pre-retirees does not receive the social stigma of work exclusion, it will present better mental health. A sample of 1332 Spanish participants aged between 51 and 69 years was randomly chosen, and various personality tests were applied, and consumption of healthcare resources was determined. Pairwise analysis of the three work situations using binary logistic regressions showed that pre-retirees present better mental health, although there were no differences in the consumption of healthcare resources. The implications of this study for the creation of health promotion policies targeting older people, depending specifically on their employment status, are discussed.

Keywords: mental health; personality; older people; retirees; workers

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1. Introduction

Western societies have seen how their citizens' life expectancy has increased considerably in recent years. Globally, although there are still important health inequalities, life expectancy has increased by 5 years since 2000 [1]. According to the European Commission [2], among the reasons for this situation are increased longevity due to medical advances and improvements in quality of life, low birth rates because of difficulties to find work, the cost of housing, the delay in having children, and the incorporation of women in the labor market, among others.

The aging process itself can lead to the decline of physical fitness and functional capacity [3]. With the aging of the population, fragility, chronicity, and long-term care need to increase [4]. To the variable age should be added other social determinants of health, such as demographic dispersion, which implies a limited access to more specific health services. Therefore, they frequently suffer physical or emotional conditions that contribute to reducing their capacity to adapt and defend themselves [5].

Older people use more health services, their hospital admissions are more frequent, and their hospital stays are longer in comparison with other age brackets [6]. This situation represents a growing public health problem [4,7].

Population ageing, coupled with the global crisis, has led to the emergence of three social groups: that of older workers (older people still working because no generational replacement has occurred [8]), poor workers (people who receive very low wages due to the economic crisis, and who are defined as workers whose incomes fall below the poverty line [9]), and pre-retired workers (people who were expelled from the labor market due to companies closing, and because, at their age, they cannot rejoin the productive system, they

have access to retirement before the regulative age [10]). We are faced with the paradox that society is becoming populated by increasingly older active workers, older people who have lost their jobs and have managed to obtain early retirement (so that, socially, they are not considered retired), and retired people. Ultimately, all these phenomena are related to age.

Various studies have examined the relationship between unemployment and mortality as a function of various causes [11], including behavioral and social risk factors [12]. Thus, some jobs involve an increased risk of death among the unemployed population, due to several causes: mental pathology [13], cardiovascular pathology [14], or cancer [15]. There is practically no research analyzing the role of pre-retirees, but some studies of unemployment (such as the last one of those mentioned) include situations of forced or obliged unemployment (different from retirement due to illness or disability). Similarly, early retirement is also considered an important variable when determining the use of health services [16].

Schoormans et al. [17] pointed out that, in some cases, the use of healthcare is not only determined by the complexity of the health process or by the patient's functional status, but also by the patient's psychological characteristics. Specific psychological characteristics may be associated with different stages of disability and, in turn, may be affected by the disability itself [18]. Hence, there is growing interest in determining how different psychological characteristics can influence older people's health [18–20], and one of those factors is integration in the working world.

One of the most studied theoretical concepts is that of self-efficacy, as it is considered an excellent predictor of many behaviors [21]. Individuals with high perceived self-efficacy are more likely to perform preventive behaviors, seek treatments earlier, and to be more optimistic about its effects [22,23]. Although self-efficacy has somewhat carelessly been associated with a decrease in survival, functional impairment, and increased risk of institutionalization of older people [24].

Has been shown to be associated with an increase of self-care among older persons [25], and with active ageing [19] and good health in general [22]. Similarly, individuals or patients who perform physical activity obtain better scores in self-efficacy compared to sedentary individuals [26]. It has also been shown to be a mediator of health-related behavioral changes and healthcare resource consumption [27,28]. Self-efficacy can be trained and improved [29,30].

Personality has been associated with physical functioning [31], with neuroticism being one of the factors with higher incidence on good performance [32]. There is also a clear link between personality and health-related quality of life [33]. Low levels of neuroticism are important predictors of successful aging [34].

We also note concepts such as subjective age, also predictive of mental and physical health in aging [35,36]. It is known that negative perceptions of aging (in the form of self-perceptions) are also a risk factor for some dimensions of physical deterioration associated with age [37]. Subjects with higher subjective age tend to be more sedentary [36], which increases the risks of developing or worsening chronic pathologies [38].

Old–old people, a group in transition between the community (residing in their homes or with relatives) and the institution (living in nursing homes), should be the potential recipients of psychological prevention measures and health promotion aimed at improving their quality of life [25].

This work aims to determine the extent to which a person's work situation leads to the presentation of a series of psychological variables that allow us to define a psychological profile, and its possible consistency with greater or lesser consumption of health services. We considered employee inclusion as a predicting variable instead of age, which is a significant contribution of this study. Our hypothesis is that actively working older people will present healthier personality variables, and lower consumption of health services, followed by pre-retirees, with retirees being those who present the least healthy values in personality variables, and higher consumption of health services.

This research is of great relevance in Spain, where the percentage of the population of people aged 65 or over (which is made up of retirees) is 34.11%, and the percentage of people in the range between 55 and 64 years (those considered as pre-retirees) is 13.28%. In other words, the population of pre-retirees plus that of retirees reaches almost half of the total population, being, therefore, a very old country.

2. Materials and Methods

2.1. Participants

A total of 1332 individuals participated, of whom 596 were men (44.7%) and 736 women (55.3%), age ranging between 51 and 69 years (M = 61.16, SD = 4.557). Of them, 809 were active workers (61%), 140 pre-retirees (10.5%), and 379 retirees (28.5%). The sample was randomly selected from the population of people older than 50 years, according to the percentages of active workers, pre-retirees, and retirees that was provided by the official agency that collects this information in the region of Galicia (NW Spain). The data of how many people make up the population of each group appear in the previous paragraph. We selected a sample of 1500 individuals, and 1416 agreed to participate, of whom 1332 fell within the indicated quotas. Therefore, the level of participation was 88.8%. For the three samples, the percentage of men and women was equal (50% in each of them). Besides, in all of them, it was verified that their health was good. In the sample of active workers, 25% had preuniversity studies, in the second (pre-retirees) this proportion was 22%, and in the third (retirees) it was 31%; the rest had university studies. In Spain, for workers in private companies, the mandatory retirement age is 65 years. However, companies in need of reducing their workforce ask the government to use early retirement, and if the government approves it, it is possible to retire early, usually between 55 and 64 years of age. Therefore, in the first of the subsamples (active workers) subjects between 50 and 64 years of age were included; in the second of the subsamples (pre-retirees) subjects between 55 and 64 years of age were included; and in the third of the samples (retirees), subjects aged 65 years or more were included.

2.2. Scales Used

The following questionnaires were applied:

- A questionnaire of sociodemographic variables that collected data about age, sex, level of completed studies, marital status, and employment status.
- A questionnaire of consumption of health services. The variables concerning health consumption (always within the last two months) were: the number of times that the person went to the medical practitioner; the number of times that the person consulted a specialist; the number of diagnostic or analytical tests carried out; and, if the person went to a rehabilitation service, the number of sessions attended.

The Zimbardo Time Perspective Inventory (ZTPI) [39]: In this study, we used the Spanish version of Díaz-Morales [40], although it has been adapted for other populations [41–43]. The scale is made up of 56 items. The form of response is the Likert type, from strongly disagree (1) to strongly agree (5), with an intermediate point (neither agree nor disagree, (3). The scale comprises five subscales: negative past (14 items); hedonistic present (14 items); future (11 items); positive past (8 items); and present fatalistic (9 items). An example of an item is "I think that getting together with friends at a party is one of the most important pleasures in life". This is the first item on the scale, which is integrated into the "hedonistic present" personality dimension. Cronbach's alpha reliability index was calculated, and the following coefficients were obtained for each subscale) following the order just explained in this paragraph: 0.85, 0.89, 0.91, 0.80, and 0.82. Therefore, the mean reliability was 0.85, which is considered very adequate.

The multidimensional locus of the control scale (internality–externality, I–E) of Levenson [44]: We used the version in Spanish by Romero-García [45]. This scale is made up of 24 items. The response form is also a Likert type but with four response alternatives, from "never" (1) to always (4); it does not have a neutral response alternative. The scale

comprises four subscales: internal control (8 items); external control by chance (8 items); external control by powerful others (8 items); and global external control (sum of the external control items by chance and by other powerful ones). An example of an item is "Whether I become a leader depends mainly on my abilities". This is the first item on the scale, which is integrated into the "internal control" dimension. Cronbach's alpha reliability index was calculated, and the following coefficients were obtained for each subscale) following the order just explained in this paragraph: 0.79, 0.85, 0.85, and 0.92 Therefore, the mean reliability was 0.85, which is considered very adequate.

The scale of psychological reactance (PR) of Hong and Page [46], based on the theory of reactance of Brehm [47], in its translated version by Perez [48]: It has two dimensions, the affective component and the cognitive component. This scale is made up of 14 items. The form of response is also Likert type and also has four response alternatives, from "never" (1) to always (4); it does not have a neutral response alternative. The scale comprises two subscales: an affective component (8 items) and a cognitive component (6 items). An example of an item is "The existence of rules and regulations trigger in me a tendency to resistance". This is the first item on the scale, which is integrated into the cognitive component. Cronbach's alpha reliability index was calculated, and the following coefficients were obtained for each subscale following the order just explained in this paragraph: 0.81 and 0.83. Therefore, the mean reliability was 0.82, which is considered very adequate.

The coping responses inventory (CRI) of Moos [49,50], in the adaptation of Ongarato et al. [51]. This scale is made up of 22 items. The form of response is also Likert type and also has four response alternatives, from "never" (1) to always (4); it does not have a neutral response alternative. An example of an item is "Do you say words to yourself to refresh yourself?". This is the first item on the scale. Cronbach's alpha reliability index was calculated, and the alpha Cronbach coefficient was 0.82, which is considered very adequate.

A scale of self-efficacy applied to health (SEH), based on the test of self-efficacy of Baessler and Schwarzer [52], created by Gandoy-Crego et al. [53]. This scale is made up of 10 items. The form of response is also the Likert type and also has four response alternatives, from "never" (1) to always (4); it does not have a neutral response alternative. The scale does not include subscales. An example of an item is "Do you say things to yourself to encourage yourself?". This is the first item on the scale. Cronbach's alpha reliability index was calculated, and a reliability coefficient of 86 was obtained, which is considered very adequate.

Coping responses inventory (CRI) of Sandín and Chorot [54]. This is a self-report measure consisting of 42 items, measuring seven dimensions, each one made up of six items: problem-solving focus, negative self-focus, positive reappraisal, open emotional expression, avoidance, social support seeking, and religion. The form of response is also a Likert type and also has four response alternatives, from "never" (1) to always (4); it does not have a neutral response alternative. An example of an item is "I tried to analyze the causes of the problem in order to deal with it". This is the first item on the scale, and it is included in the subscale "Problem-solving focus". Cronbach's alpha reliability index was calculated, and the following coefficients were obtained for each subscale) following the order just explained in this paragraph: 0.75, 0.79, 0.83, 0.81, 0.82, 0.88, and 0.83 Therefore, the mean reliability was 0.81, which is considered very adequate.

2.3. Procedure

We located the participants, first, sending them a postal explanatory letter, and then, through a home visit. The questionnaires were applied in each household. The information was collected between September and November of 2019. The data of each individual were entered in a sheet, and subsequently exported and analyzed using the statistical program.

We created an informed consent form, which explained the reason for the research, provided data of the researchers, and the possibility of the participants' requesting the deletion of his/her data from the sample set, after having facilitated it. This authorization was signed by all participants. None of them refused consent.

All of them authorized the inclusion of material pertaining to themselves, which they acknowledge that they cannot be identified via the paper, and the researchers fully anonymized them.

The committee of ethics of the university of the corresponding author approved this research. Hence, this research complied with the requirements of the Declaration of Helsinki, and those established by the American Psychological Association.

2.4. Data Analysis

In addition to calculating the corresponding statistics to determine the composition of the sample, logistic binary regressions were conducted, using personality and health resource consumption as predictor variables and variables related to the participants' employment status as dependent variables. Three logistic regressions were performed, comparing occupationally active people with pre-retirees, occupationally active people with retirees, and pre-retirees with retirees.

3. Results

The first logistic regression used being actively employed versus pre-retirement as the criterion variable. The omnibus tests on the model yielded a Chi-square value of 69.602 (df = 22), with very high significance ($p = 0.001$). After six iterations, the -2log likelihood value was 510.418, with a R2 value of 0.055, and a R2 value of. 147. The classification table shows 93.4% of correct classifications, which is very high.

As can be seen in Table 1, the significant variables of the analysis ($p < 0.05$) referred to the temporal dimension of personality (future), and to social support seeking and negative self-focus. In short, compared with active workers, pre-retirees were more oriented toward the future, seek less social support, and had less negative self-perception. All these results can be observed in Table 1.

Table 1. Binary logistic regression comparing active workers with pre-retirees.

	B	S.E.	Wald	df	Sig.	Exp(B)
Negative past	0.366	0.298	1.509	1	0.219	1.442
Hedonist present	0.089	0.301	0.087	1	0.769	1.093
Future	−0.566	0.269	4.412	1	0.036 *	0.568
Positive past	−0.435	0.239	3.296	1	0.069	0.647
Fatalist present	0.044	0.272	0.026	1	0.871	1.045
Internal control	0.587	0.371	2.505	1	0.113	1.798
Random external control	0.035	0.373	0.009	1	0.926	1.035
External control through power	0.026	0.327	0.006	1	0.937	1.026
Emotional reactance	0.389	0.310	1.574	1	0.210	1.475
Cognitive reactance	0.502	0.312	2.596	1	0.107	1.652
Cognitive coping	−0.598	0.337	3.157	1	0.076	0.550
Behavioral coping	0.203	0.299	0.460	1	0.498	1.225
Cognitive avoidance coping	0.142	0.305	0.218	1	0.640	1.153
Behavioral avoidance coping	0.477	0.265	3.237	1	0.072	1.611
Health-related self-efficacy	−0.130	0.339	0.146	1	0.703	0.878
Social support seeking	0.355	0.170	4.361	1	0.037 *	1.426
Open emotional expression	−0.270	0.251	1.163	1	0.281	0.763
Religion	0.204	0.126	2.617	1	0.106	1.226
Problem-solving focus	−0.225	0.213	1.115	1	0.291	0.799

Table 1. *Cont.*

	B	S.E.	Wald	df	Sig.	Exp(B)
Avoidance	−0.312	0.227	1.892	1	0.169	0.732
Negative self-focus	0.561	0.254	4.852	1	0.028 *	1.752
Positive reappraisal	−0.406	0.263	2.387	1	0.122	0.667
Constant	−4.089	1.895	4.656	1	0.031 *	0.017

Note: S.E.: Standard error; B: Beta coefficient; df: degrees of freedom; sign: significance; * $p < 0.05$.

The second comparison was between active workers and retirees. The omnibus tests on the model yielded a X^2 value of 117.1 (df = 22), which was highly significant ($p = 0.001$). After six iterations, the −2log likelihood value was 211.941, with a Cox and Snell R^2 of 0.094, and a R^2 value of 0.388. The classification table shows 97.45% of correct classifications, higher than the previous comparison.

As can be observed in Table 2, concerning the significant variables of the analysis ($p < 0.05$), two refer to the temporal dimension of personality (positive past and fatalistic present), one to internal control, and two of the variables are related to coping (behavioral coping and cognitive avoidance). Therefore, compared with people who are actively employed, retirees grant less value to the positive elements of their past, but they also view their present in a less fatalistic way. They also score lower in internal control, and show higher levels of behavioral coping and cognitive avoidance. The complete data are presented in Table 2.

Table 2. Binary logistic regression comparing active workers with retirees.

	B	S.E.	Wald	df	Sig.	Exp(B)
Negative past	0.096	0.511	0.035	1	0.851	1.101
Hedonist present	−0.101	0.525	0.037	1	0.847	0.904
Future	−0.515	0.483	1.136	1	0.286	0.598
Positive past	−0.971	0.367	6.995	1	0.008 **	0.379
Fatalist present	−1.643	0.489	11.304	1	0.001 **	0.193
Internal control	−2.259	0.580	15.145	1	0.000 **	0.105
Random external control	0.080	0.629	0.016	1	0.899	1.083
External control through power	0.210	0.561	0.140	1	0.708	1.234
Emotional reactance	−0.821	0.532	2.382	1	0.123	0.440
Cognitive reactance	−0.321	0.546	0.345	1	0.557	0.726
Cognitive coping	−0.308	0.635	0.235	1	0.628	0.735
Behavioral coping	1.144	0.535	4.567	1	0.033 *	3.140
Cognitive avoidance coping	1.178	0.508	5.376	1	0.020 *	3.248
Behavioral avoidance coping	0.403	0.454	0.785	1	0.376	1.496
Health-related self-efficacy	−0.015	0.553	0.001	1	0.978	0.985
Social support seeking	−0.381	0.324	1.379	1	0.240	0.683
Open emotional expression	−0.024	0.449	0.003	1	0.957	0.976
Religion	−0.057	0.238	0.058	1	0.810	0.944
Problem-solving focus	−0.463	0.361	1.644	1	0.200	0.629
Avoidance	−0.014	0.371	0.001	1	0.970	0.986
Negative self-focus	−0.595	0.463	1.654	1	0.198	0.551
Positive reappraisal	0.766	0.511	2.249	1	0.134	2.151
Constant	9.619	2.794	11.855	1	0.001 **	15054.030

Note: S.E.: Standard error; B: Beta coefficient; df: degrees of freedom; sign: significance. * $p < 0.05$; ** $p < 0.01$.

The last of the comparisons was between pre-retirees and retirees. The omnibus tests on the model yielded a Chi-square value of 80.959 (df = 22), which was highly significant ($p = 0.001$). After seven iterations, the -2log likelihood value was 63.521, with a R^2 value of 0.505, and a R^2 value of 0.707. The classification table shows 89.6% of correct classifications, somewhat lower than the previous comparisons.

As can be seen in Table 3, the significant variables of the analysis ($p < 0.05$) were internal control, cognitive reactance, cognitive avoidance coping, social support seeking, and positive reappraisal. It can be stated that retirees, compared with pre-retirees, present lower internal control, lower cognitive reactance, more cognitive avoidance coping, less social support seeking, and more positive reappraisal. The complete data are presented in Table 3.

Table 3. Binary logistic regression comparing pre-retirees with retirees.

	B	S.E.	Wald	df	Sig.	Exp(B)
Negative past	−2.003	1.250	2.568	1	0.109	0.135
Hedonist present	0.849	1.182	0.516	1	0.473	2.338
Future	−1.687	1.001	2.842	1	0.092	0.185
Positive past	0.453	0.696	0.424	1	0.515	1.573
Fatalist present	−2.096	1.079	3.772	1	0.052	0.123
Internal control	−4.212	1.310	10.339	1	0.001 **	0.015
Random external control	0.766	1.109	0.478	1	0.490	2.152
External control through power	0.553	1.015	0.297	1	0.586	1.738
Emotional reactance	−0.734	1.120	0.430	1	0.512	0.480
Cognitive reactance	−2.821	1.243	5.156	1	0.023 *	0.060
Cognitive coping	1.653	1.136	2.117	1	0.146	5.221
Behavioral coping	1.073	0.839	1.637	1	0.201	2.924
Cognitive avoidance coping	1.813	0.914	3.940	1	0.047 *	6.131
Behavioral avoidance coping	0.789	0.898	0.772	1	0.380	2.202
Health-related self-efficacy	−0.642	1.166	0.303	1	0.582	0.526
Social support seeking	−1.411	0.711	3.941	1	0.047 *	0.244
Open emotional expression	0.151	1.092	0.019	1	0.890	1.163
Religion	−0.117	0.440	0.070	1	0.791	0.890
Problem-solving focus	−0.155	0.784	0.039	1	0.843	0.856
Avoidance	−1.197	0.958	1.561	1	0.212	0.302
Negative self-focus	−0.997	0.826	1.458	1	0.227	0.369
Positive reappraisal	2.645	1.128	5.495	1	0.019*	14.078
Constant	17.937	6.482	7.657	1	0.006 **	61670336.735

Note: S.E.: Standard error; B: Beta coefficient; df: degrees of freedom; sign: significance; * $p < 0.05$; ** $p < 0.01$.

4. Discussion and Conclusions

The objective of this work was to determine to what extent the employment situation of a person translates into the manifestation of different psychological profiles, depending on whether the individuals are active workers, pre-retirees, or retirees. To this end, the hypothesis was raised that older people who actively work will present healthier personality variables, followed by early retirees, with retirees presenting the least healthy values in personality variables. The data found allowed us to affirm that the hypothesis was fulfilled when comparing active workers with retired ones, but the introduction of a subsample of pre-retired subjects did not conform to what was expected, but it totally changed the meaning of the expected profiles. The population of pre-retired subjects is the one that

presents the healthiest profile, allowing one to affirm that being in a pre-retired situation increases the state of psychological health.

The comparison between actively working individuals and retirees showed that retirees focus on their positive memories (positive past) and perceive their present in a fatalistic way. That is, they missed the past, when they were not retired. Strange to say, retirees had a higher degree of internal control than did actively employed people; that is, they attributed what goes on in their life to themselves, perhaps because they did not belong to work organizations. On the other hand, actively employed people used more behavioral coping strategies and cognitive avoidance of problematic situations, whereas retirees did not avoid thinking about such situations. Ultimately, retirees blamed themselves for their problems, they did not avoid these thoughts, and they also reinforced themselves personally by thinking about their past, and were annoyed by their present.

It is noteworthy that pre-retirees granted more value to their future, sought less social support from others, and focused less on their negative aspects than did active workers. That is, active workers presented worse mental health than did pre-retirees. When comparing pre-retirees with retirees, the data indicate that retirees presented greater internal control, greater cognitive reactance, and more social support seeking than pre-retirees; however, pre-retirees avoided thinking about negative issues and performed positive reappraisals of their situation. That is, once again, pre-retirees had better quality of health than retirees.

It is interesting that no significant differences were detected in variables such as religion, affective reactance, or other variables. In general, we found a profile very limited to a few variables, with high explanatory power. No significant differences were found in measures such as health-related self-efficacy or the consumption of health services, which contradicts studies like those of Wiener and Tilly [4], Osorio-Parraguez and Espinoza [5], or Veras [6].

The results of this research clearly show that being an active worker, a pre-retiree, or a retiree led to creating a differential profile of these three groups. We wished to introduce a group of pre-retirees, who are not usually taken into account in other studies because, even though they are not occupationally active, their social image is more positive because they have had to access retirement but do not present the usual retiree characteristics. Additionally, in fact, the data confirm this fact.

In summary (see Table 4), pre-retirees had a higher quality of mental health than did active employees and forcibly retired persons. All this shows that the preventive measures required to care for the health of older persons must be maximized in actively working older people and in forced retirees. This work is consistent with the approach of authors like Schoormans et al. [17]. Moreover, it has the advantage that it identifies the variables involved in each of the profiles, as recommended by Cooper et al. [18], Cha et al. [19], (2011), or Windsor et al. [20].

This work has a series of limitations. Perhaps the first of them is that we considered age groups of elderly people, but there are also people who are active at work with very advanced ages (including those over eighty years old), pre-retirement people with ages of 45 years in advance, and even people retired since the sixties (especially in the public sector). We considered the inclusion of employees as a predictor variable instead of age, which is a significant contribution of this study and we considered that future research should include the aforementioned groups. On the other hand, the sample was incidental in nature; obviously, it is very difficult to obtain random samples, especially from active and labor-intensive people, but we considered that future studies should try to obtain random samples.

However, we also considered that this work presents important contributions to this field of research. We believe that the identification of these profiles may allow us to develop specific programs of health promotion targeting older people, but differentiated according to their employment situation. Furthermore, the main finding of this work, that the subsample of pre-retirees is the one that presents a more suitable psychological profile

that can lead to the development of public policies that promote progressive retirement, that is, to devise procedures so that the transition from active worker to retired person is progressive.

Table 4. Overview of significant results.

	Active Worker/Pre-Retiree	Active Worker/Retiree	Pre-Retiree/Retiree
Negative past			
Hedonist present			
Future	Pre-retiree		
Positive past		Retiree	
Fatalist present		Retiree	
Internal control		Retiree	Retiree
Random external control			
External control through power			
Emotional reactance			
Cognitive reactance			Retiree
Cognitive coping			
Behavioral coping		Active worker	
Cognitive avoidance coping		Active worker	Pre-retiree
Behavioral avoidance coping			
Health-related self-efficacy			
Social support seeking	Active worker		Retiree
Open emotional expression			
Religion			
Problem-solving focus			
Avoidance			
Negative self-focus	Active worker		
Positive reappraisal			Pre-retiree

We also need to highlight that the main idea of this work, to emphasize the idea that lifestyles, and therefore psychological variables, are fundamental when it comes to explaining the well-being shown by older people, and is not something new, without this it has already been asserted for years by authors such as Rowe and Kahn [55,56], who indicated the study of non-pathological ageing, which was produced by the mere increase in age. Therefore, it is necessary to provide interventions for the elderly, aimed at identifying effective strategies to grow the proportion of the population showing successful ageing.

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References

1. World Health Organization. World Health Statistics 2020. Available online: https://www.who.int/data/gho/data/themes/theme-details/GHO/world-health-statistics (accessed on 1 March 2021).
2. European Committee. *Communication from the Commission, Confronting Demographic Change: A New Solidarity between the Generations*; European Union: Brussels, Belgium, 2005.
3. Pereira, C. Aging with dependence: Family needs and responsibilities. *Cad. Saude Publica* **2003**, *19*, 733–781.
4. Wiener, J.M.; Tilly, J. Population ageing in the United States of America: Implications for public programmes. *Int. J. Epidemiol.* **2002**, *31*, 776–781. [CrossRef]
5. Osorio-Parraguez, P.; Espinoza, A. Mental health in natural disasters: Interventional strategies on elderly in rural areas of Chile. *Glob. Health Promot.* **2016**, *23*, 84–91. [CrossRef] [PubMed]
6. Veras, R.P. *Third Age. Contemporary Health Management*; Relume-Dumará: Rio de Janeiro, Brazil, 2002.
7. United Nations. *Population Ageing and Development: Ten Years after Madrid. Population Facts 2012/4*; UN Department of Economic and Social Affairs, Population Division: New York, NY, USA, 2012.
8. Suso, A. Employment, older workers and young people. *Cuad. Relac. Labor.* **1997**, *11*, 203–235.
9. Ehrenreich, B. *Nickel and Dimed: On (Not) Getting by in America*; Henry Holt and Company: New York, NY, USA, 2010.
10. Alonso-Benito, L.E.; Fernández-Rodríguez, C.J.; Ibáñez-Rojo, R. The other excluded: The speeches of early retirement workers in Spain. *Investig. Mark.* **2010**, *106*, 42–45.
11. Roelfs, D.J.; Shor, E.; Davidson, K.W.; Schwartz, J.E. Losing life and livelihood: A systematic review and meta-analysis of unemployment and all-cause mortality. *Soc. Sci. Med.* **2011**, *72*, 840–854. [CrossRef] [PubMed]
12. Lundin, A.; Lundberg, I.; Halten, L.; Ottosson, J.; Hemmingsson, T. Unemployment and mortality—A longitudinal prospective study on selection and causation in 49321 Swedish middle-aged men. *J Epidemiol. Community Health* **2010**, *64*, 22–28. [CrossRef] [PubMed]
13. Borges, G.; Nock, M.K.; Abad, J.M.H.; Hwang, I.; Sampson, N.A.; Alonso, J.; Andrade, L.H.; Angermeyer, M.C.; Beautrais, A.; Bromet, E.; et al. Twelve-Month Prevalence of and Risk Factors for Suicide Attempts in the World Health Organization World Mental Health Surveys. *J. Clin. Psychiatry* **2010**, *71*, 1617–1628. [CrossRef] [PubMed]
14. Meneton, P.; Kesse-Guyot, E.; Méjean, C.; Fezeu, L.; Galan, P.; Hercberg, S.; Ménard, J. Unemployment is associated with high cardiovascular event rate and increased all-cause mortality in middle-aged socially privileged individuals. *Int. Arch. Occup. Environ. Health* **2015**, *86*, 707–716. [CrossRef] [PubMed]
15. Lastra-del-Prado, R.; Rodríguez-García, J.; Muñoz, P.; Gimeno, L.A. Cancer and unemployment. *Semergen* **2016**, *42*, 94–102. [CrossRef] [PubMed]
16. Hoebel, J.; Rommel, A.; Schroeder, S.L.; Fuchs, J.; Nowossadeck, E.; Lampert, T. Socioeconomic Inequalities in Health and Perceived Unmet Needs for Healthcare among the Elderly in Germany. *Int. J. Environ. Res. Public Health* **2017**, *14*, 1127. [CrossRef]
17. Schoormans, D.; Sprangers, M.A.G.; Van Melle, J.P.; Pieper, P.G.; Van Dijk, A.P.J.; Sieswerda, G.T.J.; Hulsbergen-Zwarts, M.S.; Plokker, T.H.; Brunninkhuis, L.G.H.; Vliegen, H.W.; et al. Clinical and psychological characteristics predict future healthcare use in adults with congenital heart disease. *Eur. J. Cardiovasc. Nurs.* **2016**, *15*, 72–81. [CrossRef]
18. Cooper, R.; Huisman, M.; Kuh, D.; Deeg, D.J. Do positive psychological characteristics modify the associations of physical performance with functional decline and institutionalization? Findings from the longitudinal aging study Amsterdam. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2011**, *66*, 468–477. [CrossRef] [PubMed]
19. Cha, N.H.; Seo, E.J.; Sok, S.R. Factors influencing the successful aging of older Korean adults. *Contemp. Nurse* **2012**, *41*, 78–87. [CrossRef] [PubMed]
20. Windsor, T.D.; Burns, R.A.; Byles, J.E. Age, physical functioning, and affect in midlife and older adulthood. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2013**, *68*, 395–399. [CrossRef]
21. Godoy-Izquierdo, D.; Godoy, J.F.; López-Chicheri, I.; Martínez, A.; Gutiérrez, S.; Vázquez, L. Psychometric properties of the Escala de Autoeficacia para el Afrontamiento del Estrés (EAEAE). *Psicothema* **2008**, *20*, 155–165. [PubMed]
22. Grembowski, D.; Patrick, D.; Diehr, P.; Durham, M.; Beresford, S.; Kay, E.; Hecht, J. Self-Efficacy and Behavior among Older Adults. *J. Health Soc. Behav.* **1993**, *34*, 89–104. [CrossRef] [PubMed]
23. Olivari, C.; Urra, E. Self-efficacy and Health Behaviors. *Cienc. Enfermería* **2007**, *13*, 9–15.
24. Surtees, P.G.; Wainwright, N.W.; Luben, R.; Khaw, K.T.; Day, N.E. Mastery, sense of coherence, and mortality: Evidence of independent associations from the EPIC-Norfolk Prospective Cohort Study. *Health Psychol.* **2006**, *25*, 102–110. [CrossRef]
25. Kostka, T.; Jachimowicz, V. Relationship of quality of life to dispositional optimism, health locus of control and self-efficacy in older subjects living in different environments. *Qual. Life Res.* **2010**, *19*, 351–361. [CrossRef]
26. Boix, S.; León-Zarceño, E.; Serrano-Rosa, M.A. Identification with physical exercise and self-efficacy: Differences between practioners of pilates vs non-practitioners. *Rev. Iberoam. Psicol. Ejerc. Deporte* **2017**, *12*, 99–106.

27. Anderson, E.S.; Winett, R.A.; Wojcik, J.R.; Williams, D.M. Social cognitive mediators of change in a group randomized nutrition and physical activity intervention: Social support, self-efficacy, outcome expectations and self-regulation in the guide-to-health trial. *J. Health Psychol.* **2010**, *15*, 21–32. [CrossRef]
28. Lorig, K.R.; Ritter, P.; Stewart, A.L.; Sobel, D.S.; Brown, B.W.; Bandura, A.; Gonzalez, V.M.; Laurent, D.D.; Holman, H.R. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Med. Care* **2001**, *39*, 1217–1223. [CrossRef]
29. Marks, R.; Allegrante, J.P.; Lorig, K. A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: Implications for health education practice (part I). *Health Promot. Pract.* **2005**, *6*, 37–43. [CrossRef]
30. Scult, M.; Haime, V.; Jacquart, J.; Takahashi, J.; Moscowitz, B.; Webster, A.; Denninger, J.W.; Mehta, D.H. A healthy aging program for older adults: Effects on self-efficacy and morale. *Adv. Mind Body Med.* **2015**, *29*, 26–33. [PubMed]
31. Suchy, Y.; Williams, P.G.; Kraybill, M.L.; Franchow, E.; Butner, J. Instrumental activities of daily living among community-dwelling older adults: Personality associations with self-report, performance, and awareness of functional difficulties. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2010**, *65*, 542–550. [CrossRef] [PubMed]
32. Canada, B.; Stephan, Y.; Jaconelli, A.; Duberstein, P.R. The moderating effect of chronological age on the relation between neuroticism and physical functioning: Cross-sectional evidence from two French samples. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2014**, *71*, 35–40. [CrossRef] [PubMed]
33. Huang, I.C.; Lee, J.L.; Ketheeswaran, P.; Jones, C.M.; Revicki, D.A.; Wu, A.W. Does personality affect health-related quality of life? A systematic review. *PLoS ONE* **2017**, *12*, e0173806. [CrossRef] [PubMed]
34. Baek, Y.; Martin, P.; Ilene, C.S.; Davey, A.; Poon, L.W. Personality traits and successful aging: Findings from the Georgia centenarian study. *Int. J. Aging Hum. Dev.* **2016**, *83*, 207–227. [CrossRef] [PubMed]
35. Choi, N.G.; DiNitto, D.M. Felt age and cognitive-affective depressive symptoms in late life. *Aging Ment. Health* **2014**, *18*, 833–837. [CrossRef]
36. Stephan, Y.; Sutin, A.R.; Caudroit, J.; Terracciano, A. Subjective age and changes in memory in older adults. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2016**, *71*, 675–683. [CrossRef]
37. Robertson, D.A.; Savva, G.M.; King-Kallimanis, B.L.; Kenny, R.A. Negative perceptions of aging and decline walking speed: A self-fulfilling prophecy. *PLoS ONE* **2015**, *10*, e0123260. [CrossRef]
38. Stephan, Y.; Sutin, A.R.; Terracciano, A. Feeling Older and Risk of Hospitalization: Evidence from three longitudinal cohorts. *Health Psychol.* **2016**, *35*, 634–637. [CrossRef]
39. Zimbardo, P.G.; Boyd, N. Putting Time in Perspectiva: A Valid, Reliable, Individual-Differences Metric. *J. Pers. Soc. Psychol.* **1999**, *17*, 1271–1288. [CrossRef]
40. Diaz-Morales, J.F. Factorial structure and reliability Inventory Zimbardo's Time Perspective. *Psicothema* **2006**, *18*, 565–571. [PubMed]
41. Anagnostopoulos, F.; Griva, F. Exploring time perspective in Greek young adults: Validation of the Zimbardo Time Perspective Inventory and relationship with mental health indicators. *Soc. Indic. Res.* **2012**, *106*, 41–59. [CrossRef]
42. Apostolidis, T.; Fieulaine, N. French Validation of the Temporal Scale: The Zimbardo Time Perspective Inventory (ZTPI). *Eur. Rev. Appl. Psychol.* **2004**, *54*, 207–217. [CrossRef]
43. Ortuño, V.; Gamboa, V. Factorial structure of Zimbardo Time Perspective Inventory—ZTPI in a simple of Portuguese university students. *Av. Psicol. Latinoam.* **2009**, *27*, 21–32.
44. Levenson, H. Multidimensional Locus of Control in Psychiatric Patients. *J. Consult. Clin. Psychol.* **1973**, *41*, 397–404. [CrossRef] [PubMed]
45. Romero-Garcia, O. Internality as Motivation, Incentive Value of the Studies and Intellectual Execution. Ph.D. Thesis, Universidad de Mérida, Mérida, Spain, 1983.
46. Hong, S.; Page, S. A Psychological Reactance Scale: Development, factor structure and reliability. *Psychol. Rep.* **1989**, *64*, 1323–1326. [CrossRef]
47. Brehm, J.W. *A Theory of Psychological Reactance*; Academic Press: New York, NY, USA, 1966.
48. Perez, A.M. Dimensionality of the Construct "Locus of Control". *Rev. Psicol. Gen. Appl.* **1984**, *39*, 471–488.
49. Moos, R.H. *Coping Responses Inventory-Adult Form*; Psychological Assessment Resources: Odessa, TX, USA, 1993.
50. Moos, R.H. Development and Application of New Measures of Life Stressors, Social Resources and Coping Responses. *Eur. J. Psychol. Assess.* **1995**, *11*, 1–13. [CrossRef]
51. Ongarato, P.; De la Iglesia, G.; Stover, J.B.; Fernández-Liporace, M. Coping Responses Inventory: An Adaptation to Adolescent and Adult Population. *Anu. Investig. UBA* **2009**, *16*, 383–391.
52. Baessler, J.; Schwarzer, R. Evaluation of the Self-efficacy: Spanish Adjustment of the Scale of General Self-efficacy. *Ansiedad Estrés* **1996**, *2*, 1–8.
53. Gandoy-Crego, M.; Clemente, M.; Gómez-Cantorna, C.; González-Rodríguez, R.; Reig-Botella, A. Self-efficacy and health: The SEH Scale. *Am. J. Health Behav.* **2016**, *40*, 389–395. [CrossRef]
54. Sandin, B.; Chorot, P. Stress Coping Questionnaire (CAE): Development and Preliminary Validation. *Rev. Psicopatol. Psicol. Clín.* **2003**, *8*, 39–54.
55. Rowe, J.W.; Kahn, R.L. *Successful Aging*; Random House: New York, NY, USA, 1988.
56. Rowe, J.W.; Kahn, R.L. Human aging: Usual and successful. *Science* **1987**, *237*, 143–149. [CrossRef] [PubMed]